Frequently Asked Questions

Why do we need the LNF methodology?

Congress directed IHS to report health care funding deficiencies for tribes. The LNF methodology was developed following guidelines in federal statute. The Congress also directed the IHS to allocate IHCIF funds using the LNF methodology.

Will the methodology result in funding decreases?

No. The methodology is designed to identify additional funding needs and allocate additional funds to places with the greatest needs. There are no plans to redistribute existing funding.

Does the LNF study recommend replacing the IHS with a insurance plan?

No. The LNF study uses a typical mainstream health plan as a reference to compare funding needs of Indian people with health funding available to persons covered by insurance plans. Using that standard, the study found a large gap in needed funding. Neither the LNF work group nor the IHS has proposed moving towards an insurance model. Rather, work group members say that local programs can design operate their own health programs if sufficiently funded.

Are Urban Indians included in the IHCIF?

No. The LNF study identified 4 sub-groups of eligible Indians to which the methodology may be applied. One of these groups was urban Indians residing in 34 cities with existing urban projects. The LNF methodology could be applied to Urban funding allocations if that is desired.

How does the LNF findings compare to the tribal budget formulation process?

The LNF study addresses a rather narrow question: "what amount of funding is necessary to make Indian health funding comparable to mainstream health plans." The tribal budget formulation process uses a much broader definition which includes personal health services, all wrap-around programs, and additional health services not now provided. While the funding benchmark in the LNF study was explicitly developed to allow "apples-to-apples" comparisons, the tribal budget formulation process use larger spending benchmarks from Medicaid which include programs not part of typical health plans. Also, the tribal budget includes expanding users from 1.4 to 1.8 million including 332,000 urban Indians. Finally, the tribal budget includes an additional $8 billion for infrastructure expansion and improvement that is not assumed in the "apples-to-apples" LNF study.

Are LNF findings inconsistent with the tribal developed budget request?

Not necessarily. The deficiencies identified in the LNF methodology are substantially smaller, but this largely due to the narrow scope of LNF which focuses only on personal health care as compared to the broad and comprehensive definitions used in the tribal budget process.